

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003233
State File No. 2 850
Registrar's No.

FILED FEB 10 1959

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo.</i> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St. Louis, Mo.</i>		c. CITY OR TOWN <i>St. Louis 2169</i>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Incarnate Word Hospital</i>		e. STREET ADDRESS (If rural, give location) <i>3148 Magnolia</i>	

3. NAME OF DECEASED (Type or Print)	a. (First) <i>Michael</i>	b. (Middle) <i>Joseph</i>	c. (Last) <i>McCourt</i>	4. DATE OF DEATH (Month) (Day) (Year) <i>1 24 1959</i>
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5. SEX <i>Male 0</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, 0 WIDOWED, DIVORCED (Specify) <i>NEVER MARRIED</i>	8. DATE OF BIRTH <i>1-23-59</i>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Mins. <i>20 20</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and State or Foreign Country) <i>St. Louis, Missouri</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13a. FATHER'S NAME <i>Bruce Sherwood McCourt</i>	13b. MOTHER'S MAIDEN NAME <i>Carol Ann Schuler</i>	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>	16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT'S SIGNATURE OR NAME <i>BRUCE McCOURT</i>	ADDRESS <i>3148 MAGNOLIA</i>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>No natural atelectasis</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Premature birth</i> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>762.5</i>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <i>2</i> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from ~~11:20 AM~~ *1-23 1959*, to ~~7:30 PM~~ *1-24 1959* that I last saw the deceased alive on *1-24*, 1959, and that death occurred at *7:20* p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Albert E. Kozlowski MD</i>	23b. ADDRESS <i>3284 Ivanhoe</i>	23c. DATE SIGNED <i>1-25-59</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	24b. DATE <i>1/26/1959</i>	24c. NAME OF CEMETERY OR CREMATORY <i>LAKEWOOD PARK CEM.</i>	24d. LOCATION (City, town, or county) (State) <i>St. Louis Mo.</i>
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DATE REC'D BY LOCAL REG. <i>JAN 26 '59</i>	REGISTRAR'S SIGNATURE <i>Carl Smith MDJ L</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>ZIEGENHEIN & SONS</i>	ADDRESS <i>7027 GRAVOIS</i>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

14
165
0

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by no embalming, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Vernon Heater.....

Licensed Embalmer No.....

P. O. Address 7027 Grant.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.